MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

April 2009

CENTER FOR INFORMATION SYSTEMS AND ANALYSIS

Maryland Trauma Physician Services Fund

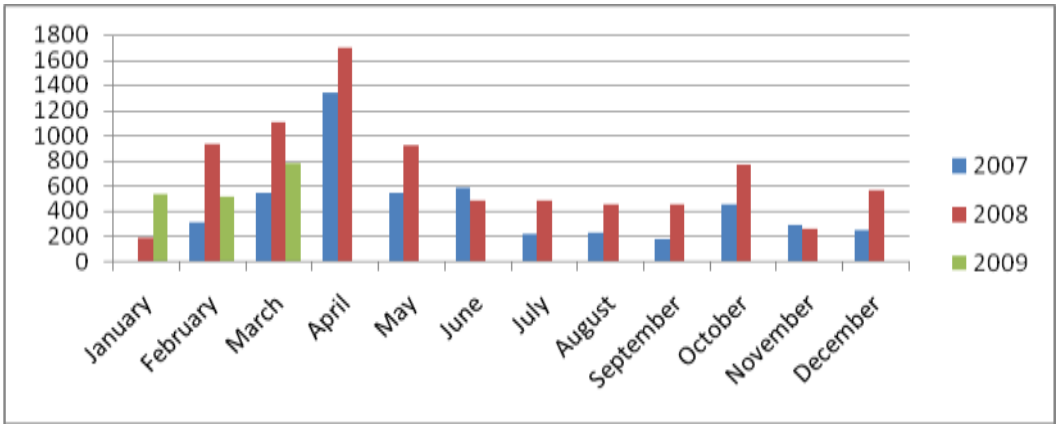
MHCC recently conducted an analysis of spending trends for the Maryland Trauma Physician Services Fund. In FY 2009, MHCC estimates that total disbursements will use all of the $12.9 appropriation from the Fund. Growth in uncompensated care has been a major factor driving increases in total payments. The recent economic turmoil and the resulting job losses have pushed more Maryland residents into the ranks of the uninsured. Trauma services provided to uninsured patients that do not have the financial resources to pay are reimbursed through the Fund.

The Commission is required to maintain solvency in the Fund under the law. Drawing down from the Fund's reserve is not the only, or necessarily the most desirable, option for closing the probable spending shortfall in 2010. Maryland's Budget Reconciliation and Financing Act of 2009 (HB 101, SB 166) will reallocate $17 million of the $20 million dollar reserve to other needs in FY 2010. Although approximately $3 million will remain in the reserve, the Commission will need to consider other options before using the remaining reserve. The staff expects to submit options to the Commission in May for eliminating the projected shortfall in FY 2010.

Uncompensated Care Processing

CoreSource, Inc., the third party administrator (TPA) for the Trauma Fund, adjudicated claims with a total paid value of approximately $776,776 in March. The monthly payments for uncompensated care since February 2007 are shown below in Figure 1.

Figure 1 – Uncompensated Care Payments 2007-2009



RFP for Audit Services
The Commission has released an RFP that will award a contract for auditing of the Maryland Trauma Physician Services Fund and the Health Insurance Partnership. Proposals were due not later than 4:00 p.m. on April 8, 2009.

Cost and Quality Analysis

Medical Care Data Base
Staff released the 2008 Medical Care Data Base (MCDB) Submission Manual to the insurance companies and HMOs (payers) that submit privately insured claims to the MHCC. Under Commission regulation at COMAR 10.25.06, twenty-three payers have been identified as collecting more than $1 million in health insurance premiums, which requires them to submit claims data to the MCDB. Payers must submit their 2008 claims data by July 6, 2008. The 2008 MCDB submission manual includes several new reporting requirements and a new way for payers to submit their data. The new reporting requirements include replacing the "patient liability" field on both the Professional Services file and the Prescription Drug file with three new variables that parse patient liability into three potential sources of liability: patient deductible; patient coinsurance/copayment; and other patient obligations (e.g., balance billing, non-covered services). This change will permit the MHCC to study trends in coinsurance/co-payment levels for particular types of services and trends in deductible levels, in addition to total patient liability. The new data submission option permits payers to transfer their data to MHCC by uploading it to a secure FTP (file transfer protocol) server—provided the payer has a secure FTP client—eliminating the need to physically transfer data on electronic media such CDs. Data from the MCDB supports analyses for several Commission reports and issue briefs, including the annual reports on State Health Care Expenditures and Practitioner Utilization and Expenditures. Because the quality of the payer data affects the value of these reports and studies, staff would like to improve the quality of the data submissions. Consequently, this year we have established specific error thresholds for critical variables; submissions that do not meet these thresholds will be returned unless a waiver was obtained by the payer. The Manual is available on the MHCC website on the Payer Compliance page.

Consumer-Directed Health Plans (CDHPs) in Maryland: Does Spending Differ for Enrollees
Consumer-directed health plans (CDHPs) are health benefits plans featuring high deductibles and are usually associated with a tax-favored health reimbursement account (HRA) or a health savings account (HSA). By having consumers pay the upfront costs of health care directly, CDHPs are intended to encourage more cost-conscious spending through choice of health care providers, managing use of services, and changes in health behaviors. Claudia Schur, PhD, of Social and Scientific Systems is conducting a study for the MHCC that uses MCDB data to examine enrollment by Maryland residents in CDHPs for 2006 and 2007 and comparing the characteristics of CDHP enrollees to residents enrolled in traditional health plans. Health expenditures—both payer-reimbursed and out-of-pocket portions—will be compared for CDHP enrollees and others, controlling for risk status. Health expenditure comparisons will include total annual spending for professional services, as well as annual spending for particular types of professional services. Additionally, the study will compare the hospitalization rates among the two groups of enrollees, adjusted for risk status.

Primary Care Medical Home Workgroup
One of the recommendations of the Governor's Task Force on Health Care Access and Reimbursement, was that the newly established Quality and Cost Council should be charged with creating a uniform statewide approach to assist physician practices in establishing medical homes by:

- Promoting the formation of medical homes based on the American College of Physicians' (ACP's) principles for medical homes;
- Creating multi-stakeholder coalitions composed of payers, providers, and purchasers that will develop common reimbursement and performance incentives for medical homes;

- Identifying equitable sources of start-up funding so that initial costs can be shared among providers, payers, and purchasers commensurate with the longer-term benefits; and
- Mobilizing the multi-stakeholder coalitions to compete for medical home demonstrations offered by CMS and various nonprofit organizations.

The Council subsequently created a Primary Care Medical Home Workgroup, with the goal of developing a multi-stakeholder medical home program that can be presented to the Governor by November of 2009. MHCC will staff this workgroup.

Internet Activities

Figure 2 presents results on web utilization for the Commission's ten most frequently visited sites for February and March 2009. The total number of Visits in March increased about 10.5% from February to March after allowing for the additional 3 days in March, ending with over 29,000 visits.

The Nursing Home Guide had the highest utilization in March, with the Hospital Guide close second. The Guides (Nursing Home, Hospital, and Assisted Living) continued to have significant traffic during the month; visits to these sites represent about 34 percent of all visits.

A number of other changes are noteworthy. MHCC uses our web portal for the user fee assessment of hospitals, nursing homes, and insurances companies. The assessment process begins in March, so that site experienced a dramatic and expected increase in access. Electronic Health access also increased by 10 percent due in part to growing interest on the part of providers in adoption. As a result of the American Reconstruction and Recovery Act, the federal government will award state grants and direct payments via Medicare and Medicaid to physicians that adopt EHRs. In parallel, the General Assembly is considering requiring private payers to provide monetary incentives for EHR adoption.

Several web analytics continued to trend favorably during the past two months. The average number of pages viewed and the average time on the site were steady. About 34% of all visitors originated from a Maryland-based ISP, about the same as in February. Those visitors tend to view more pages and spend longer time on the site.

Figure 2: Visits to the MHCC Web Sites
Top 10 MHCC Sites during February & March 2009

Web Development for Internal Applications
Staff continued to make progress on license renewal applications for the occupation boards. Table 1 presents the status on development for health occupation boards. The current workload and the limited staff available for develop has forced MHCC to scale back support to the Boards in the last several months.

Table 1– Health Occupation Boards with Web Applications Under Development

Board	Anticipated Start Development/Renewal	Start of Next Renewal Cycle
Physician's – Licensed Respiratory Care	Development	
Physicians – Nuclear Medicine Therapist	Development	
Physician- Radiation Technicians/Therapists/Radiographers	Planning	April 2009
Physicians – Physician Assistants	Planning	June 2009
Chiropractic Examiners	Planning	Fall 2009
Optometry	Development	April 2009
Nursing Home Survey Redesign	Development	Summer 2009
AHRQ QI Installation	Planning	Spring 2009

CENTERS FOR HEALTH CARE FINANCING AND LONG-TERM CARE AND COMMUNITY BASED SERVICES

HMO Quality and Performance

2009 Performance Evaluation: HEDIS Audit and CAHPS Survey

HEDIS Audit
HealthcareData.com (HDC), the audit contractor, has many audit activities in progress: clinical measure code review, examination of baseline information, onsite interviews, and in-depth review activities related to HMO and PPO health plans. All plans have completed an automated review for several measures using a tool designed by NCQA to ensure their IT systems accurately capture data.

Consumer Assessment of Health Plan Study (CAHPS Survey)
As a check on the survey process, Division staff has been seeded for each of the four scheduled mailings going to a representative sample from each plan. The first questionnaire was mailed in early March followed by a reminder postcard. Performance standards set by this Division require the vendor to use a tracking method to monitor mail delivery with an expected result of 100% of seed items received by staff. WB&A used the certified mail method to track mailings with a result of 100% delivered to the addressee. The response rate after the first mailing is similar for HMO and PPO health plans.

Report Development—State Employee Guide
Health Plan Quality & Performance Division staff finalized text, layout, and data for the *Measuring the Quality of Maryland Commercial Managed Care Plans: 2009/2010 State Employee Guide* —the last report in the three report series. The report will be posted on the Commission's website to coincide with state employee's open enrollment period. Staff worked with DBM in drafting segments for inclusion in

the employee benefit booklet and other notifications about open enrollment and availability of the health plan comparative report. Distribution of enrollment materials for state employees is scheduled to occur April 10-17.

Small Group Market

Comprehensive Standard Health Benefit Plan (CSHBP)
At the March public meeting, the Commission adopted final regulations to implement the following changes to the CSHBP: requiring coverage for certain child dependents up to age 25, and requiring coverage for the surgical treatment of morbid obesity. These coverage changes will be implemented effective July 1, 2009.

Each year, carriers participating in the small group market are required to submit to the Commission completed survey forms that include enrollment and premium information in the CSHBP for the preceding calendar year. This year's analysis is based on data for the calendar year ending December 31, 2008. Commission staff is in the process of analyzing these data and will present the findings of these surveys at the May public meeting.

Health Insurance Partnership
The premium subsidy program known as "The Partnership" is currently available to certain small employers with 2 to 9 full time employees as long as they meet the requirements outlined in the law and meet certain salary, wage and other eligibility requirements established by the Commission through regulation. Coverage under the Partnership began on October 1, 2008. As of April 7th, enrollment in the Partnership was as follows: 152 employer groups; 426 employees; 700 covered lives. The average subsidy per enrolled employee is $1,824; the average age of all enrolled employees is 39; the group average wage is $28,000; the average number of employees per policy is 3.9; and the total subsidy amount issued is $777,000.

Commission staff created and continually maintains the Partnership website (http://mhcc.maryland.gov/partnership) to inform all interested parties, including, carriers, producers, employers, employees, various business associations, etc., about this subsidy program.

Mandated Health Insurance Services
As required under Insurance Article § 15-1501, Annotated Code of Maryland, the Commission is required to submit an annual report to the General Assembly on: (1) any proposed mandated health insurance service that failed during the preceding legislative session; and (2) any request for analysis on a proposed mandated benefit that was submitted by a Legislator to the Commission by July 1st of that year. Each evaluation must include an assessment on the medical, financial, and social impact of the proposed mandate. The 2008 report, prepared by Mercer, the Commission's consulting actuary, included an evaluation on the following five (5) proposed mandates: coverage for prosthetic devices; extending the current mandate on coverage for in vitro fertilization; coverage for the shingles (herpes zoster) vaccine; coverage for autism spectrum disorder; and coverage for a 48-hour inpatient stay following a mastectomy. At the December 2008 meeting, the Commission approved the report, which was submitted to the Governor and the General Assembly prior to its due date of December 31, 2008. We will provide an update on any additional proposed mandates to be reviewed during 2009.

Long Term Care Policy and Planning

Nursing Home Occupancy and Medicaid Participation
Data on nursing home occupancy and Medicaid participation rates is updated periodically and published in the *Maryland Register* to guide Certificate of Need decisions and other planning functions. The following tables were submitted to the *Maryland Register* for publication in the April 10th issue: Nursing Home Licensed Beds Occupancy by Region and Jurisdiction: Maryland, Fiscal Year 2006; Required Maryland Medical Assistance Participation Rates for Nursing Homes by Region and Jurisdiction, Fiscal Year 2006; Nursing Home Licensed Beds Occupancy by Region and Jurisdiction: Maryland, Fiscal Year 2007; Required Maryland Medical Assistance Participation Rates for Nursing Homes by Region and Jurisdiction, Fiscal Year 2007.

Long Term Care Survey
Staff is preparing for the release of the FY 2008 survey in June. We are currently reevaluating the long term care survey application to eliminate questions that have exhausted their usefulness, restructure questions to make them clearer to the reader and adding questions to support the expansion of the web based Long Term Care Guide. Staff anticipates both internal and external meetings for input with this redesign and enhancement to the content of the survey question. The 2007 public use data sets are available to the public on the Commission's website

Long Term Care Quality Initiative

Nursing Home Family Experience of Care Survey
The 2008 Maryland Nursing Home Family Experience of Care Survey results were released to the public March 19, 2009. Several print stories were run in the Baltimore Sun and independents with several local newspapers scheduled to print the story over the next few weeks. Carol Christmyer also did two live interviews on WBAL (NBC) and WMAR (ABC). Both interviews focused on the survey's utility for consumers and nursing homes, and the collaborative effort that resulted in a 59% response rate.

Work has begun on the contract renewal for the 2009 survey year. Nursing homes are having an increasing number of short stay residents and trends in long term care indicate that this cohort will continue to increase with time. MHCC's staff is collaborating with the Agency for Healthcare Research and Quality (AHRQ) to utilize the ARHQ short stay discharge survey in Maryland during the 2009 survey cycle. This collaboration would benefit AHRQ by providing additional testing of the instrument while MHCC would benefit by piloting an "experience of care survey" with former nursing home short stay residents.

Other
Staff is studying the potential impact of MDS 3.0 conversion on various long term care reports. The implementation of MDS 3.0 has been delayed until October 2010.

CENTER FOR HOSPITAL SERVICES

Hospital Services Policy and Planning

Certificate of Need (CON)

- **CONs Issued**

Manor Care-Bowie (Prince George's County) – Docket No. 08-16-2249
Establish a 120-bed comprehensive care facility ("CCF") to be located on Fairwood Parkway in Prince George's County. The project replaces and relocates 100 licensed or temporarily delicensed beds from Heartland Health Care Center–Adelphi, and 20 licensed beds from Heartland Health Care Center–Hyattsville
Cost: $14,897,003

Augsburg Lutheran Home (Baltimore County) – Docket No. 08-03-2284
Construct a 3-story addition to the CCF component of this retirement community campus and renovate the CCF
Cost: $16,653,690

Holly Hill Nursing & Rehabilitation Center (Baltimore County) – Docket No. 08-03-2285
Construct a 4-level addition (basement and 3 levels above-grade), adding 20 CCF beds (replacing and relocating 20 CCF beds from Little Sisters of the Poor/St. Martin's Home for the Aged) and renovating the existing facility.
Cost: $3,657,475.

- **Acquisitions**

Harford Hospice
Acquisition of Harford Hospice, a general hospice serving Baltimore City and Baltimore, Cecil and Harford Counties, by Amedisys, Inc.

Upper Chesapeake/St. Joseph Home Care, Inc.
Acquisition of Upper Chesapeake/St. Joseph Home Care, Inc., a general home health agency serving Baltimore City and Baltimore, Cecil and Harford Counties, by Amedisys, Inc.

- **Capital Threshold**

Holy Cross Hospital (Montgomery County)
Establish a 10-bed observation unit on the ground floor of the east building.
Cost: $1,300,000

- **Delicensure of Bed Capacity or a Health Care Facility**

South River Health & Rehabilitation Center (Anne Arundel County)
Temporary delicensure of 9 CCF beds

- **Relinquishment of Bed Capacity**

Oak Crest Village Care Center (Baltimore County)
Permanent relinquishment of 8 CCF beds

- **Other**

Private Surgical Suite, L.L.C. (Montgomery County)
Change in the ownership structure of this outpatient surgical facility

MidShore Eye Center (Talbot County)
Addition of physicians to the medical staff of this outpatient surgical facility

- **Ambulatory Surgery Centers**

Sandal Center for Facial Plastic Surgery (Anne Arundel County)
Establish an ambulatory surgery center with 1 non-sterile procedure room to be located at 127 Lubrano Drive, Suite 102, Annapolis

J. Bernard Dayhoof Building for Medical Specialties (Harford County)
Establish an ambulatory surgery center with 1 non-sterile procedure room to be located at 21 Eastern Avenue, Bel Air

Maryland Diagnostic and Therapeutic Endo Center, LLC (Anne Arundel County)
Establish an ambulatory surgery center with 3 non-sterile procedure rooms to be located at 612 Ridgley Avenue, Suite 105, Annapolis

Tri-County Endoscopy Center (Calvert County)
Establish an ambulatory surgery center with 1 non-sterile procedure room to be located at 130 Hospital Road, Suite 300, Prince Frederick

Summit Ambulatory Surgical Center, L.L.C. (Howard County)
Establish an ambulatory surgery center with 1 operating room and 1 non-sterile procedure room to be located at 7625 Maple Lawn Boulevard, Suite 205, Maple Lawn

- "**Waiver" Beds**

Fairfield Nursing Center (Anne Arundel County)
Addition of 8 CCF beds

Potomac Ridge at Anne Arundel County (Anne Arundel County)
Addition of 2 residential treatment center beds

Policy and Planning

On March 6, 2009, Center for Hospital Services and Center for Health Information Technology staff met with an informal work group of surgical facility representatives to review and receive input on proposed changes in MHCC's Annual Survey of Freestanding Ambulatory Surgical Facilities. Several new questions relating to board certification of medical staff, hospital privileges maintained by practitioners on staff at freestanding surgical facilities, and transfers of patients from freestanding surgical facilities to hospitals, are proposed for addition to the survey this year (collecting information for CY2008). Information gathered through these questions will be included in the Maryland Ambulatory Surgery Facility Consumer Guide. Additionally, a supplemental survey on the use of health information

technology by freestanding ambulatory surgical facilities will be an addition to this year's general survey and this was also reviewed by the work group.

A new Schedule for Certificate of Need Review was published in the Maryland Register on March 27, 2009. This Schedule provides information on letter of intent due dates, pre-application conference dates, and application submission dates for eight project categories covering, in most cases, the next two review cycles for these categories.

Hospital Quality Initiatives

- **Hospital Performance Evaluation Guide (HPEG) Advisory Committee**

The HPEG Advisory Committee held its monthly meeting on March 23rd to discuss various activities associated with the maintenance and expansion of the Hospital Performance Evaluation Guide (HPEG). The staff reviewed the status of new quality measures data collection and reporting including implementation issues surrounding the Children's Asthma Care Measure. Staff reviewed the status of the establishment of the Quality Measures Data Center (QMDC) designed to support the Hospital Performance Evaluation System and proposed plans for a statewide hospital briefing to present this new initiative to the industry. The meeting has been scheduled for June 23rd and will be co-sponsored with the Maryland Hospital Association. The QMDC will collect, analyze and maintain patient level data on CMS clinical quality measures, the Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) measures and other relevant quality information. Staff reported on its outreach efforts to hospitals and their vendors to facilitate a smooth transition to the new system and updated the group on the development of the new website that will allow hospitals to transmit their data directly to the Commission. The QMDC will provide direct and timely access to detailed patient-level quality and performance measures data. This approach will not only accelerate the timely receipt of data directly from hospitals, but it will enable the Commission to validate the accuracy and completeness of the data as well.

- **Healthcare Associated Infections (HAI) Data**

Staff, under the guidance of the Healthcare Associated Infections (HAI) Advisory Committee, has developed the *2009 Annual Survey of Maryland Hospital Infection Prevention and Control Programs.* The Survey is designed to collect information on the staffing, operations and activities of hospital infection prevention and control programs in Maryland. It represents an enhancement of the first survey conducted in 2007. The survey is a web-based tool that will assist the Commission in understanding the basic characteristics of hospital programs and inform statewide HAI public reporting and quality improvement initiatives. The deadline for hospital submission of the completed surveys is April 24, 2009. The survey results will be summarized and disseminated to the hospitals.

- **Other Activities**

Staff attended a workshop on March 11-12, 2009 on the National Healthcare Safety Network (NHSN) surveillance system. NHSN is an internet-based surveillance system that has been the vehicle for collecting Central Line Associated Blood Stream Infection (CLABSI) data from Maryland hospitals since July 1, 2008. Staff attended the workshop to enhance their understanding of the technical reporting requirements associated with the surveillance system and to prepare for the possible expansion of HAI data collection through other NHSN modules. The staff also participates in the NHSN State Users monthly teleconferences to stay abreast of issues surrounding HAI hospital performance measures.
In support of MHCC's hospital quality initiatives, the staff continues to reach out to other units within DHMH, federal agencies, professional organizations and other states, to share and gather information and to identify opportunities for collaboration and improvement. The staff continues to collaborate with the HSCRC staff on data issues to support the Quality Based Reimbursement project and broader rate setting issues.

Specialized Services Policy and Planning

The State Health Plan for Cardiac Surgery and Percutaneous Coronary Intervention Services (COMAR 10.24.17) requires Maryland hospitals without on-site cardiac surgery to obtain a waiver to provide primary percutaneous coronary intervention (pPCI), which is the emergency use of catheter-based techniques, including balloon angioplasty, to relieve coronary vessel narrowing in patients with ST-segment elevation myocardial infarction (STEMI). The Commission will issue a pPCI waiver for a two-year period, provided that the applicant hospital meets and continues to meet all requirements for pPCI programs without on-site cardiac surgery. On February 19, 2009, the Commission granted a two-year waiver to Frederick Memorial Hospital (Docket No. 08-10-0036 WR) and to Washington County Hospital (Docket No. 08-21-0037 WR); on March 19th, the Commission issued a two-year waiver to Upper Chesapeake Medical Center (Docket No. 08-12-0038 WR). On April 7th, Shady Grove Adventist Hospital timely filed the application to renew the hospital's two-year pPCI waiver.

Through a clinical registry established in January 2006, the Commission collects data on STEMI patients presenting at hospitals that have a pPCI waiver. This registry provides the audited data necessary to measure each pPCI program's compliance with certain regulatory requirements, including patient eligibility, door-to-balloon times, and institutional volume. The annual report for calendar year 2008 was distributed at the public meeting on March 19th, and is available at: http://mhcc.maryland.gov/hospital_services/specialservices/cardiovascular/ppci.html.

COMAR 10.24.05 Research Waiver Applications: Atlantic C-PORT Study of Nonprimary Percutaneous Coronary Intervention (npPCI) provides for a limited number of qualified hospitals without on-site cardiac surgical services to participate in an elective angioplasty study conducted by the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT E) in multiple states. The objective of this randomized clinical research trial is to determine whether npPCI performed in hospitals without on-site cardiac surgery services is as safe and effective as npPCI performed in hospitals with on-site cardiac surgery services. On March 19th, the Commission adopted the Executive Director's Recommendation that the Commission grant waivers to participate in the C-PORT E study to Frederick Memorial Hospital (Docket No. 08-10-0034 NPRW) and Washington County Hospital (Docket No. 08-21-0035 NPRW). Both hospitals are located in the Western Maryland Regional Service Area. The Commission Decision is available on the Commission's website at: http://mhcc.maryland.gov/hospital_services/specialservices/cardiovascular/nppci.html. Commission staff will meet with Thomas Aversano, M.D., the principal investigator of the C-PORT E study; Cynthia Lemmon, R.N., C-PORT E Nurse Coordinator; and representatives of each of the two hospitals to review key issues related to the npPCI waiver program.

COMAR 10.24.05 established a two-phase review; the first phase involved research waiver applications from eligible hospitals in the Metropolitan Baltimore and Metropolitan Washington regional service areas. On September 18, 2008, the Commission granted research waivers to four applicants: Anne Arundel Medical Center (Docket No. 08-02-0032 NPRW), Shady Grove Adventist Hospital (Docket No. 08-15-0027 NPRW), Southern Maryland Hospital Center (Docket No. 08-16-0031 NPRW), and St. Agnes Hospital (Docket No. 08-24-0028 NPRW). The Commission took no action on the applications filed by Baltimore Washington Medical Center (Docket No. 08-02-0029 NPRW), Holy Cross Hospital (Docket No. 08-15-0033 NPRW), and Johns Hopkins Bayview Medical Center (Docket No. 08-24-0030 NPRW), pending the completion of the review of applications from the Western Maryland Regional Service Area.

At its public meeting on March 19, 2009, the Commission adopted emergency and proposed amendments to COMAR 10.24.05 that would permit the Commission to consider granting npPCI research waivers to a maximum of three additional hospitals whose applications were docketed and pending as of March 18, 2009. Available for the Commission's consideration at that time were the hospital-specific data in the 2008 pPCI report and information about the status of the C-PORT E study as of February 3, 2009. In

accordance with the Commission's September 18, 2008 Partial Final Decision, Commission staff has requested additional data on the actual and estimated case volumes of these hospitals. The three hospitals must submit the information no later than Thursday, April 30, 2009, which is the final closing date for the October to December 2008 hospital discharge abstract data.

On March 13th, the Commission invited informal public comment on the draft proposed amendments to COMAR 10.24.17, Table A-1, shown below. Single underline indicates text to be added. [Single brackets] indicate text to be deleted.

> **Category**: Institutional Resources
> 2) All institutions should provide primary PCI as soon as possible and not to exceed [120] 90 minutes from patient arrival (i.e., door-to-balloon time of ≤ [120] 90 minutes) for [80] 75 percent of appropriate patients.

This proposal will make the regulation consistent with the 2007 Focused Update of the American College of Cardiology/American Heart Association 2004 Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction. Written comments on the draft proposed changes were due by March 31st. The Commission received comments from the following: Adventist HealthCare; Calvert Memorial Hospital; Carroll Hospital Center; Frederick Memorial Hospital; Greater Baltimore Medical Center (GBMC)-Johns Hopkins Heart Center; Holy Cross Hospital; Johns Hopkins Health System; and Saint Agnes Hospital. The Commission will take action regarding adoption of the proposed amendments at its public meeting on April 16th. The process to amend the existing regulations will include an opportunity for formal public comment.

On March 18th, the Commission convened a meeting of the 13 hospitals with pPCI waivers, along with the Medical Coordinator and Senior Nurse Manager of the STEMI Registry, to discuss clinical and data management issues. Held at Shady Grove Adventist Hospital (SGAH), the work session included a summary of 2008 data from the Commission's STEMI Registry; a presentation on SGAH's Code STEMI process, which is designed to provide immediate and appropriate intervention to any patient having an acute STEMI while in SGAH; a presentation on Institutional pPCI Volume and Mortality: The C-PORT Experience; and a discussion of the current and proposed door-to-balloon time established for patients undergoing pPCI for STEMI.

CENTER FOR HEALTH INFORMATION TECHNOLOGY

Health Information Technology

Staff is in the preliminary stage of drafting an information brief based on the responses from the *2008 Hospital Health Information Technology Survey* (survey). Staff expects to complete the draft in April and circulate this brief to select hospital chief information officers (CIOs) for comment. The information brief will provide an overview of the acute care hospital's current HIT activities, and compare the findings with national hospital health information technology (HIT) activity. The survey also includes an assessment of the hospital's planning efforts, which is not included in most national HIT surveys. The information brief reports on HIT adoption by hospital size, geographical location, and hospital system affiliation. Staff plans on releasing additional information briefs from the survey later in the year. Over the next month, staff plans to work with CIOs to develop a hospital comparison scoring method for the survey in future years. Staff plans to work with the Center for Hospital Services to evaluate whether to include the survey as part of its annual *Maryland Hospital Performance Evaluation Guide*. The annual *Maryland Freestanding Ambulatory Surgical Center Survey* will include a similar survey when it is released in April.

A focus group consisting of members from the former Task Force to Study Electronic Health Records (Task Force) is scheduled to meet in April. Over the past several months, former members of the Task Force have expressed an interest in reviewing the 13 recommendations included in the final report that was sent to the Governor and General Assembly in December 2007. Staff worked with the Task Force's Chair and Vice Chair to assemble a focus group consisting of members from the original Task Force. The meeting in April will allow the Task Force to determine the relevance of the recommendations as it relates to the *American Recovery and Reinvestment Act of 2009*. The 2005 legislative directive of the Task Force was to study electronic health record (EHR) systems; the current and potential expansion of their utilization in Maryland, including the use of electronic transfer, e-prescribing, and computerized provider order entry; and the cost of implementing these functions. The Task Force also studied the impact of the current and potential expansion of school health records and issues related to patient safety and privacy. Approximately 20 out of the 27 legislatively appointed members from the Task Force and about 10 key contributors to the final report are scheduled to take part in the focus group discussion. Staff will release a briefing document from the focus group's discussion during the second quarter of 2009.

Staff continues to work on an initiative to advance HIT adoption in nursing homes. This initiative is aimed at expanding the use of HIT through awareness and a consensus-based approach to identifying a range of options for electronic health records (EHRs) adoption that includes an administrative services approach and a web-based and client server-based approach. Staff plans to invite stakeholders to participate in a workgroup that addresses privacy and security policy barriers and technical solutions that advance EHR adoption in nursing homes. Over the last month, staff identified key questions to include in an environmental scan. Information obtained from the environmental scan will be used by stakeholders to identify ways to increase EHR adoption. As part of this initiative, staff plans to develop a product portfolio that includes only those vendors that meet the most stringent Certification Commission for Healthcare Information Technology standards relating to functionality, interoperability, and security. The product portfolio will include user references, basic product information, pricing, and privacy and security policies. Staff anticipates releasing a report based on these findings in the third quarter of 2009.

Work on a draft of a briefing document related to an evaluation of various management services organization (MSO) business models continued in March. MSOs are entities that centralize the administrative and technical functions for physician practices. MSOs have the potential to increase HIT adoption, particularly among physician practices where the cost of implementing the technology is often a deterrent. Over the last six months, staff completed an analysis of the different MSO models that exist in the industry, ranging from hospital affiliation to independent organizations. MSOs eliminate the need for an onsite client server by offering a subscription-based, hosted EHR model, also known as an Application Service Provider (ASP). An ASP model allows physicians to own the data without managing the security of the information. Technical support, system maintenance, data backup, and privacy and security are addressed by the MSO. A briefing document is tentatively scheduled for release in May.

Health Information Exchange

Staff completed the assessment of The Chesapeake Regional Information System for our Patients and the Montgomery County Health Information Exchange Collaborative planning reports for *A Citizen Centric Health Information Exchange for Maryland.* Both teams submitted a final report to the Commission on February 20th. Information from the reports was used to identify key components for a statewide health information exchange (HIE) related to governance, privacy and security, role-based access, user authentication and trust hierarchies, architecture of the exchange, hardware and software solutions, costs of implementation, alternative sustainable business models, and strategies to assure appropriate consumer engagement, access, and control over information exchange. Over the last month, with the assistance of the firm Health Care Information Consultants, staff developed a *Design Specification for the Maryland HIE*. Staff reviewed this document with information gathered from approximately ten HIEs operating elsewhere around the nation. In some instances, the design specifications were modified to reflect the work of these HIEs. Staff used the design specifications in drafting the HIE Implementation RFA. The RFA is tentatively scheduled for release around the end of April.

In the fall of 2008, a workgroup consisting primarily of CIOs was convened to develop a core set of policies that address community data sharing related to electronic health information. The workgroup addressed a number of issues that included a patient's right to control their information; a range of business practices for privacy and security; technical standards; and key financial, organizational, and clinical barriers to exchanging electronic data. The *Service Area Health Information Exchange (SAHIE) Resource Guide* (Guide) emerged as a result of this work and released in March. The Guide identifies key policy and best practices for communities planning to exchange electronic patient information.

Maryland is one of ten states participating in the Health Information Security & Privacy Collaboration's (HISPC) Adoption of Standards Collaborative Workgroup (workgroup) led by the Office of the National Coordinator for Health Information Technology (ONC). Last month, ONC extended by four months the HISPC contract in order for the workgroup to complete proof of concept testing on a series of consumer and provider policies related to authorization and access of immunization registries. States participating in the workgroup are required to test a series of policy toolkits on privacy and security as part of the contract extension. During the month, ONC provided feedback on the draft recommendation contained in the final report *National Health Bridge: Basic Policy Requirements for Authentication and Audit*. The final report is due to ONC in April 2009.

Staff continues to provide support to the Electronic Health Network Accreditation Commission's (EHNAC) HIE Policy Accreditation Advisory Panel (advisory panel). EHNAC convened an advisory panel last fall to develop privacy and security policy criteria recommendations to include in their HIE network accreditation program. The advisory panel met virtually on a monthly basis over the last six months. In March, the advisory panel addressed policy issues related to the storing and transmission of clinical data over a public and private health information exchange. The advisory panel consists of nearly 50 representatives from different stakeholder groups across the nation. EHNAC anticipates making this accreditation program available to HIEs in 2010.

Electronic Health Networks & Electronic Data Interchange

Staff completed testing of the web-enabled EDI application used by payers to submit their annual EDI Progress Report. Over the last couple of months, staff made several enhancements to the online application that payers use to enter in their census-based administrative transaction data. Payers will receive their user ID and password, data entry instructions, copies of last year's submission, and contact support information in early April. Payers have until June 30th to submit an EDI Progress Report, as required by COMAR 10.25.09, *Requirements for Payers to Designate Electronic Health Networks*. These regulations require payers to submit data on their administrative health care transactions for the previous year if their premium volume is one million dollars or more. This is the second year that payers will report their administrative health care transaction using a web-based application.

Staff awarded electronic health network (network) initial two-year certification to Quadax and recertified RxHub, SSI Group, Ancillary Network Services, Medical Claims Corporation, EDI Health Group and Tesia-PCI. Staff continues to provide support to approximately five networks interested in the Maryland market. Testing is underway for an online application for networks to use in submitting their MHCC EHN Certification and Recertification Application. Currently, networks must complete a paper application by downloading it from the MHCC website. Staff expects the web-enabled application to be available beginning in May. Last month, staff completed an analysis of the proposed Drug Enforcement Agency's e-prescribing regulations for controlled substances and EHNAC's e-prescribing criteria used by networks that exchange pharmacy transactions. Staff findings of the analysis will be forwarded to EHNAC's criteria committee for consideration of potential modifications to their e-prescribing criteria.

National Networking

Staff participated in several webinars during the month: The State-Level Health Information Exchange (SLHIE) Consensus Project webinar through the Foundation of Research and Education of the American

Health Information Management Association, which focused on Governance and Stages of Readiness based on the American Recovery and Reinvestment Act of 2009; the eHealth Initiative webinar that focused on the successful experience and lessons learned from the development of the *e-Prescribe Florida Collaborative*; and the eHealth Initiative webinar on physician insights on the challenges and benefits of bringing e-prescribing into their practice, and the different models used in e-prescribing.